FORM NLRB-4477

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

(Santa Rosa, California)

SANTA ROSA MEMORIAL HOSPITAL

Employer

and

TEAMSTERS LOCAL NO. 624, INTERNATIONAL BROTHERHOOD OF TEAMSTERS, AFL-CIO **1/**

Petitioner

20-RC-17514
20-RC-17515

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9*(c)* of the National Labor Relations Act, as amended, a hearing was held before a hearing officer of the National Labor Relations Board; hereinafter referred to as the Board.

Pursuant to the provisions of Section 3*(b)* of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record in this proceeding, the undersigned finds:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

2. The Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein. **2/**

3. The labor organization*(s)* involved claim*(s)* to represent certain employees of the Employer. **3/**

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9*(c)(1)* and Section 2*(6)* and *(7)* of the Act.

5. The following employees of the Employer constitute a unit appropriate for the purpose of collective bargaining within the meaning of Section 9*(b)* of the Act:

All full-time and regular part-time technical and non-professional employees employed by the Employer at its 1165 Montgomery Avenue, Santa Rosa, California, facility, Patient Transporter, Secretary, Material Handler, CME Coordinator, Cook, Dietary Aide, Dietary Porter, Dietary Worker, EEG/EKG Tech, Care Partner, Service Partner, Environmental Services Aide, Clinical Lab Assistant, Medical Records Clerk, Medical Records Transcriber, Medical Records Coder, Coordinator of Medical Staff Services, Credentialing Coordinator, Staffing Secretary, Anesthesia Tech, Equipment Tech, Inventory Tech, Operating Room Tech, Data Entry/PBX Operator, Pharmacy Technicians, Physical Therapy Aide, Physical Therapy Assistant, Central Services Tech, Cardiovascular Tech, Radiology Tech, Orthopedics Tech, Cardiopulmonary Tech, LVN Licensed Vocational Nurse, Nuclear Medicine Tech, Nuclear Medicine/Ultrasound Tech, Ultrasound Tech, Respiratory Therapist, Surgical Technologist, Hardware Specialist, Systems Administrator, Programmer, Information Systems Hub Coordinator, Information Systems Clinical Coordinator, Network Analyst and Associate Analyst, Renal Transplant Assistant, Life Learning Coordinator, Program Manager Life Learning, Program Registration Life Learning, Office Manager/Coordinator/Nursing Secretary (Jennifer Welch), Telemetry Tech, Health Information Assistant, Admissions Representatives, Financial Counselors, Coordinator for Cardiology, Database Coordinator, Resource Assistant, Inventory Controller, Diet Coordinator, Admissions Representative in the

ER, Tumor Registrar, Out-Patient Registration/Clinical Assistant, Perinatal Specialist, Engineering Coordinator, Wound Care Specialist, Pathology Coordinator and Medical Staff Coordinator; **4/** excluding all other employees,**5/** business office clerical employees,**6/** confidential employees,**7/** guards and supervisors as defined in the Act.

DIRECTION OF ELECTION

An election by secret ballot shall be conducted by the undersigned among the employees in the unit*(s)* found appropriate at the time and place set forth in the notice of election to be issued subsequently, subject to the Board's Rules and Regulations. Eligible to vote are those in the unit*(s)* who were employed during the payroll period ending immediately preceding the date of this Decision, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Also eligible are employees engaged in an economic strike which commenced less than 12 months before the election date and who retained their status as such during the eligibility period and their replacements. Those in the military services of the United States may vote if they appear in person at the polls. Ineligible to vote are employees who have quit or been discharged for cause since the designated payroll period, employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date, and employees engaged in an economic strike which commenced more than 12 months before the election date and who have been permanently replaced. Those eligible shall vote whether or not they desire to be represented for collective bargaining purposes by Teamsters Local No. 624, International Brotherhood of Teamsters, AFL-CIO**.**

LIST OF VOTERS

In order to insure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters and their addresses which may be used to communicate with them. **Excelsior Underwear, Inc**., 156 NLRB 1236 (1966); **NLRB. Wyman-Gordan Company**, 394 U.S. 759 (1969). Accordingly, it is hereby directed that with 7 days of the date of this Decision 3 copies of an election eligibility list, containing the full names and addresses of all the eligible voters, shall be filed by the Employer with the undersigned who shall make the list available to all parties to the election. **North Macon Health Care Facility**, 315 NLRB No. 50 (1994). In order to be timely filed, such list must be received in the Regional Office, 901 Market Street, Suite 400, San Francisco, California 94103, on or before **May 10, 1999.** No extension of time to file this list shall be granted except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the requirement here imposed.

RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the **Executive Secretary, 1099-14th Street, NW, Washington, DC 20570-0001**. This request must be received by the Board in Washington by **May 17, 1999.**

Dated May 3, 1999

at San Francisco, California

/s/ Joseph P. Norelli
Acting Regional Director, Region 20

1/ The Petitioner's name appears as stipulated to by the parties at the hearing.

2/ The parties stipulated, and I find, that the Employer is a California non-profit corporation with a place of business in Santa Rosa, California and is engaged in business as an acute care hospital. During the twelve months ending March 31, 1999, in the course and conduct of its business, the Employer received gross revenues in excess of $250,000. During the same period, the Employer purchased and received goods and/or services valued in excess of $5,000 that originated outside the State of California. Based on the parties' stipulation, I find that the Employer is engaged in commerce and that it will effectuate the purposes and policies of the Act to assert jurisdiction in this case.

3/ The parties stipulated, and I find, that the Petitioner is a labor organization within the meaning of the Act.

4/ At the hearing, the parties agreed by stipulation that the specific technical and non-professional job classifications listed in the above unit description should be included in the unit. The parties further stipulated that the following Administrative Assistants should be included in the unit: Lisa Wolfe, June Douglas, Kim Matheson, and Melanie Canchola. The parties stipulated that although Administrative Assistant Diane Hogrefe would otherwise be included in the technical and non-professional bargaining unit, to the extent that she is part of the disputed Neighborhood Care Program / Community Benefits Department, her inclusion in the unit is subject to dispute because she works in a separate location. The parties agree that if the Neighborhood Care Program employees are appropriately included in the bargaining unit then Hogrefe should also be included. Finally, the parties stipulated that the remaining Administrative Assistants (including Yolanda Felder and Patricia Crowell) are to be excluded as confidential employees.

By its petitions, as amended at the hearing, the Petitioner seeks a unit comprised of all full-time and regular part-time technical and non-professional employees employed by the Employer at its hospital located at 1165 Montgomery Avenue, Santa Rosa, California, excluding all other employees, guards and supervisors as defined in the Act. Contrary to the Petitioner, the Employer contends that the unit should include technical and non-professional employees employed in its Community Benefits Department facility located at 789 Lombardi Court in Santa Rosa and its Rohnert Park Health Care Center, located at 1450 Medical Center Drive in Rohnert Park, California. Specifically, the Employer would include in the petitioned-for unit six Neighborhood Care Workers and a part-time administrative assistant employed at its Community Benefits Department facility as well as the four care partners and four radiology technologists and one relief radiology technologist employed at its Rohnert Park facility. The Petitioner asserts that the single hospital facility unit is an appropriate unit. However, the Petitioner agrees that the above-listed employees should be included in the unit if a multi-facility unit is found to be appropriate.

The Employer operates a 225 bed licensed acute care hospital providing in-patient and out-patient services at its facility located at 1165 Montgomery Avenue in Santa Rosa. The registered nurses at the hospital are represented for purposes of collective bargaining by the Santa Rosa Staff Nurses' Association and the stationary engineers at this facility are represented by an unidentified union, Local 39. The remainder of the Employer's employees are unrepresented.

The Rhonert Park Clinic

The Employer's Executive Director of Ancillary Services and Clinic Services, Edith Merritt-Driver, testified that the Rohnert Park Clinic is located approximately seven miles from the Employer's Santa Rosa hospital facility and was established to meet the urgent care needs of the Rohnert Park community. The Rohnert Park facility is a walk-in outpatient and emergency care clinic that is open for business 12 hours per day, seven days per week, and sees about 12,000 patients per year. According to Merritt-Driver, the Rohnert Park facility is staffed by 11 full-time equivalent employees in the classifications of physician, registered nurse (RN), care partner and radiology technologist. More specifically, eight RNs, four radiation technologists (plus a relief radiation technologist from the Santa Rosa facility) and six care partners are employed at the Rhonert Park clinic. (However, the radiation technologists' work schedule that was placed into evidence lists seven names.) The care partners answer the telephone, greet patients, register patients in the computer upon their arrival, assist the RNs, prepare patients for examination, take vital signs and help with stocking supplies.

Merritt-Driver testified that radiation technologists Bill Payne, Val Hurley and Tina (last name not identified) all worked at Santa Rosa before going to work at the Rohnert Park facility. Payne was employed at to the Rohnert Park clinic in 1988 after having been laid off from the Santa Rosa hospital for about a month. Hurley started at the Santa Rosa hospital but went to work at the Rohnert Park clinic after two weeks. Tina, a Santa Rosa hospital employee, who was on maternity leave at the time of the hearing, temporarily worked at the Rohnert Park clinic because of limitations imposed by her doctor during her pregnancy. Merritt-Driver testified that Leo Gaciacano, the relief radiation technologist at the Santa Rosa hospital, is also regularly scheduled to work at the Rohnert Park clinic. The record reflects that a few months before the hearing in the instant case, the radiation technologists from both facilities met at the hospital in Santa Rosa to discuss a proposal to centrally schedule all the radiation technologists out of the Santa Rosa hospital. There was no explanation of how this change would affect the scheduling of radiation technologists at the clinic. Moreover, this proposal had not been implemented as of the date of the hearing.

The record does not reflect how often radiation technologists from the Santa Rosa hospital substitute for radiologists at the Rohnert Park clinic on an unscheduled basis. Merritt-Driver generally testified that if there was a sick call, or something unusual that happened, and the resources of the hospital were needed at Rohnert

Park, those resources of the hospital would be deployed, as needed, whether it be a radiation technologist or a nurse or any other classification. Merritt-Driver testified that RNs from the Santa Rosa hospital fill in for RNs at the Rohnert Park clinic and that RNs also transfer back and forth between the two facilities. According to Merritt-Driver, if the Rohnert Park clinic is short of RNs, it looks first to increase the hours of part-time employees at Rohnert Park, but also calls upon the nursing supervisor at Santa Rosa for staffing. The record reflects that the physician group that supplies emergency room doctors to the Santa Rosa hospital also provides coverage for the Rohnert Park clinic. The record reflects that in calendar year 1998, of the 12,000 patients treated at the Rohnert Park clinic, only 63 patients were referred to the Santa Rosa hospital for additional treatment.

All of the above-listed Rohnert Park job classifications are also found at the Santa Rosa hospital where they perform similar tasks using the same types of equipment. The Employer considers the Rohnert Park clinic to be a department of the Santa Rosa hospital, and it is a cost center within the overall hospital budget. Rohnert Park employees wear employee identification badges that identify them as employees of Santa Rosa Memorial Hospital.

The Rohnert Park clinic is supervised by Assistant Nurse Manager Marie Rogers, who reports to Merritt-Driver. Rogers' predecessor in this position, Pat Batoosingh, went to work at the Santa Rosa hospital in October 1998. Rogers does not supervise any employees at the hospital. Merritt-Driver testified that she speaks with Rogers by telephone two to three times a week and meets with her in person at least once every two weeks. According to Merritt-Driver, the Rohnert Park employees receive the same employee handbook and are subject to the same personnel, administrative and clinical policies as the hospital employees. Employees at the Rohnert Park clinic are paid according to the same pay scale and receive the same benefits package as employees at the Santa Rosa hospital. Employees at the Rohnert Park clinic receive the same new hire orientation and are required to take the same physical exam as employees at the Santa Rosa hospital. Personnel files for employees at the Rohnert Park clinic are maintained both in the office of the Assistant Nurse Manager at Rohnert Park and in the Human Resources Department at the Santa Rosa hospital. The Assistant Nurse Manager at the Rhonert Park clinic handles most of the disciplinary matters at the clinic on her own, with involvement by Merritt-Driver and the Director of Human Resources in instances involving termination. The record reflects that Merritt-Driver signs off on evaluations and merit pay increases for employees at the Rohnert Park clinic.

According to Merritt-Driver, job openings at the Rohnert Park clinic are posted by the Human Resources Department at the Santa Rosa hospital. Employees at the Rohnert Park clinic similarly may bid on job openings at the Santa Rosa hospital. Employee seniority is the same for both locations. The engineering, information systems and personnel functions for the Rohnert Park clinic are provided by the Santa Rosa hospital. Patient billing is transmitted by computer from Rhonert Park to Santa Rosa and is completed by the hospital's billing department. Similarly, the

employees at the Rohnert Park clinic use the same type of computer time-clock system to record their hours as employees at the Santa Rosa hospital, and the information is transmitted to a central Payroll Department in the Santa Rosa facility after being approved by the Assistant Nurse Manager at the Rohnert Park clinic. (During a period of time when the Rohnert Park clinic did not have anyone in the Assistant Nurse Manager position, employee time information was approved by a supervisor in the Imaging Department at the Santa Rosa hospital.) Identical paychecks are issued to employees at the Rohnert Park clinic and the Santa Rosa hospital by that office. Employees at the Rohnert Park clinic who are not on direct deposit must come to the payroll office at the Santa Rosa hospital to pick up their paychecks. Environmental services for the Rohnert Park clinic are provided by an outside contractor that is overseen by the Environmental Services Department at the Santa Rosa hospital.

Merritt-Driver testified that the Rohnert Park employees are invited to attend monthly employee forums, resource fairs and other social events along with employees at the Santa Rosa hospital. The topics for employee forums, which are open meetings attended on a walk-in basis, are announced by postings and calendars that are distributed to employees. At least one employee at the Rohnert Park clinic has served on one of numerous employee committees, such as the Values Committee, along with hospital employees. Employees at the Rohnert Park clinic receive the same monthly employee newsletter published by the Employer as employees at the Santa Rosa hospital.

Community Benefit/Neighborhood Care Program Employees

The Employer's Executive Director of Social Action and Advocacy, Jill Sandersfeld, testified concerning the Neighborhood Care Program within the Community Benefit Department. According to the Employer's organizational chart, the Community Benefit Department is comprised of the Life Learning Center and the Advocacy Department headed by Sandersfeld. Sandersfeld reports to the Employer's Vice President for Area Community Benefits, Sister Michaela Rock, who, in 1994, expanded the Employer's community programs to better serve the needs of the Santa Rosa area. The Community Benefits Department is located at 789 Lombardi Court, in Santa Rosa, about four miles from the hospital. The record reflects that the reason this office is not located on the main campus of the Santa Rosa hospital is that there was no room at the hospital at the time the department was formed, so the department took separate office space in the neighborhood in which it was working at the time.

Sandersfeld oversees the Neighborhood Care Staff, whose work consists of going door to door to identify community health and safety issues and acting as a catalyst in organizing community action to improve the quality of life in the community it serves. Sandersfeld testified that Neighborhood Care workers focus their energy around either a geographic location or a neighborhood in which there are quality of life issues. The Neighborhood Care workers talk with each community member

about how they envision their community, i.e., do they feel safe, are they having problems with infrastructure. After the Neighborhood Care worker determines what the community sees as their agenda, they bring neighborhood people together in issue oriented groups, to discuss such topics as street traffic, help them brainstorm and solve their problem, and help them then make contacts with people who can solve the problem.

Due to the need to meet and communicate with community members at night and on weekends, employees in the Neighborhood Care Program work a flexible 40-hour work week. Neighborhood Care Program employees spend about half their time in the field and half of their time in the office.

Three of the six individuals who currently work as neighborhood care workers previously worked at the hospital. The positions which they filled were posted in the hospital. These individuals retained their hospital seniority following their employment at the Neighborhood Care Program. The record reflects that their previous hospital positions are unrelated to their current positions. (More specifically, Neighborhood Care Program employee Arnolfo Baragan worked on the dock in the Environmental Services Department, while Michael Viloria was employed in the Finance Department, and Sharon Marchetti was employed in the O.R.) Because Sandersfeld testified that during the past three to four months "We" hired three new Neighborhood Care Program workers, the record is unclear as to whether Sandersfeld does the hiring. A high school degree is required for the position of Neighborhood Care Worker, but no license or certificate is required. When Neighborhood Care Program employees are out sick or on vacation, no one from the hospital substitutes for them. Nor do Neighborhood Care Program employees substitute for absent hospital workers. The record reflects that Sandersfeld does not supervise any employees at the hospital.

Diane Hogrefe is employed in Neighborhood Care Program as an administrative assistant. Hogrefe's time is shared with Executive Director of Mission Services Larry Maniscalco, whose office is also at Lombardi Court. Hogrefe reports to Sandersfeld for her work in the Neighborhood Care Program. Hogrefe's work for the Neighborhood Care Program involves answering the phone, writing letters, soliciting information, scheduling appointments for the organizers and Sandersfeld, setting up meetings and functions, and going to the hospital on daily errands.

Neighborhood Care Program employees receive the same employee handbook and are subject to the same personnel, administrative and clinical policies as employees at the Rhonert Park Clinic and the Santa Rosa the hospital. Neighborhood Care Program employees are paid according to the same pay scale and receive the same benefits package as employees at the hospital and the Rhonert Park clinic. Neighborhood Care Program employees also receive the same new hire orientation and are required to take the same physical exam as hospital and clinic employees. The record reflects that the Employer maintains personnel files for the Neighborhood Care Program employees in the Human Resources Department at the Santa Rosa

hospital. Their employee health files are kept in a central location with other employee health files. Neighborhood Care Program employees wear employee identification badges that identify them as employees of Santa Rosa Memorial Hospital. The record is silent about who handles disciplinary matters and employee evaluations for Neighborhood Care Program employees.

According to Sandersfeld, Neighborhood Care Program employees receive the same employee newsletter as employees at the hospital and the clinic, attend the same employee forums and serve on the same employee committees as other employees. The record also reflects that Neighborhood Care Program employees sometimes socialize with hospital employees during their respective lunch breaks.

Sandersfeld estimated that Neighborhood Care employees make about three trips to the hospital each week for strictly business reasons. In this regard, the record reflects that Neighborhood Care Program employees go to the hospital to drop off bulk mail and pick up food and supplies for meetings from the nutrition department. Neighborhood Care Program employees also use a hospital van on occasion to take people to meetings. The Neighborhood Care Program has its own cost center and budget within the Employer's overall budget.

Sandersfeld testified that she approves the timecards of Neighborhood Care Program employees before sending them to the Employer's payroll department for processing. The three newest employees in the Neighborhood Care Program pick up their paychecks at the Employer's payroll office on Montgomery Drive. The record reflects that the Neighborhood Care Program is serviced by the Employer's information services and engineering departments. Environmental services for the Neighborhood Care Program are provided by a contracted service overseen by the Employer's Environmental Services Department.

Neighborhood Care Program employees recruit other hospital employees to volunteer to perform community services such as tree planting or neighborhood clean up projects. Neighborhood Care Program employees prepare reports on their activities, including a newspaper format report entitled “A Shared Vision, A Publication Focusing on Healthier Communities.” Once a year, Neighborhood Care Program employees hold meetings with all of the Employer's employees to share the results of their efforts and answer questions. Neighborhood Care Program employees are subject to the JACHO audit process and as such had to have their disaster plan up to date.

The record reflects that Neighborhood Care Program employees are currently designing a quick study module on healthy communities for the Employer’s Life Long Learning Center, which is located in a mobile facility across the street from the hospital campus. All employees of the Employer are required to take and pass the quick study modules on the hospital disaster plan and safety plan.

Analysis

It is well settled that a single-facility unit is presumptively appropriate for purposes of collective bargaining. In determining whether the presumption has been rebutted and only a larger, multi-location unit is appropriate, the Board examines and weighs traditional community of interest factors. Those factors include: geographic proximity of the facilities; employee interchange and interaction between facilities; the degree of operational and functional integration between the facilities; administrative centralization; similarity in the skills, functions, interests and working conditions of the employees in the two facilities; the degree of local autonomy or common supervision and control; and bargaining history. The Board's traditional approach in applying a rebuttable presumption that single-facility units are appropriate in the health care industry was reaffirmed in Manor Healthcare Corp., 285 NLRB 224 (1987). Based upon the record facts, I conclude that the Employer in this case has not rebutted the presumption that the petitioned-for single-facility unit is an appropriate unit.

In so concluding, I have considered the various arguments submitted by the Employer in support of its multi-facility unit argument, but find them to be unpersuasive in light of the limited degree of employee interaction and interchange evidenced in this case. Contrary to the Employer's argument, the Board has not found centralized control of labor relations and personnel management to be a critical factor, particularly in the absence of a significant degree of employee interchange. For example, in Manor Healthcare, above, the Board made it clear that even where several facilities are physically close together and operated under a high degree of administrative centralization, with uniform policies and procedures for all employees, a single-facility unit was nonetheless an appropriate unit. Accord: Visiting Nurses Assn. Of Central Illinois, 324 NLRB 55, 56 (1997); Samaritan Health Services, 238 NLRB 629, 633 (1978); Montefiore Hospital and Medical Center, 235 NLRB 241 (1978); University of Pittsburgh Medical Center, 313 NLRB 1341, 1342 (1994); California Pacific Medical Center, 312 NLRB 920 (1993), enfd. 87 F. 304 (9th Cir.1996); Mercywood Health Building, 287 NLRB 1114, 1116 (1988), enf. denied sub nom NLRB v McAuley Health Center, 885 F.2d 344 (6th Cir. 1989). Manor Healthcare and Mercywood Health Building, 287 NLRB at 1116 , establish that there must be substantial evidence of regular interaction and interchange between the employees of different facilities for a petitioner's desire for a single-facility unit to be rejected.

Thus in Manor Healthcare the Board rejected a multi-facility finding on the grounds that the employee interchange was "negligible." 285 NLRB at 228. Similarly, in Samaritan Health Services, 238 NLRB at 633, the Board noted "the absence of substantial interchange on either a temporary or permanent basis." In Montefiore Hospital and Medical Center, 235 NLRB 241 (1978), the Board noted the "minimal" evidence of employee interchange. And, in Pomona Golden Age Convalescent Hospital, 265 NLRB 1313, 1314 (1982), the Board found "insignificant interchange" where there were no temporary transfers within the past year. Finally, in University

of Pittsburgh Medical Center, 313 NLRB at1342, the employer conceded there was lack of contact between the skilled maintenance employees of its two side-by-side facilities and the Board found there was no interchange between the two groups. See also California Pacific Medical Center, 312 NLRB 920 ("almost no interchange"); Mercywood Health Building, 287 NLRB 1114, 1116 ("no evidence of interchange"); Visiting Nurses Assn. Of Central Illinois, 324 NLRB at 56 ("limited employee interchange" or "only minimal interchange" found despite the existence of substantial permanent transfers.)

By contrast, in those cases where the single-facility presumption was rebutted, the employee interchange was significant. In Presbyterian/St. Luke's Medical Center, 289 NLRB 249 (1988), the Board found a multi-facility health care unit to be appropriate based upon significant contact and interchange of employees among the three facilities. In that case, some employees floated among the facilities and other employees could cover for each other on the same job at the other facilities. Similarly, in West Jersey Health System, 293 NLRB 749 (1989), cited in the Employer's brief, there was evidence that employees in many job classifications in the unit regularly rotated between facilities or regularly worked on a temporary basis at divisions other than their permanent placement.

In contrast to Manor Healthcare, Mercywood Health and the other cases cited above, there is little evidence of the kind of functional integration of the three facilities which would necessitate regular contact and interchange between the employees of the three facilities. As to the Rohnert Park facility, the only regular interchange is with respect to the relief radiation technologist, Leo Gaciacano, who works relief at both the Santa Rosa and Rohnert Park facilities. However, Gaciacano is only one out of five (or six or seven) radiation technologists who work at Rohnert Park. Where only a small percentage of unit employees is engaged in regular temporary interchange, the Board has not found it sufficient to rebut the presumptive appropriateness of the single facility unit. Samaritan Health Services, above, 238 NLRB at 632; California Pacific Medical Center, above (no evidence of significant and regular interchange between non-supervisory employees of those facilities); Visiting Nurses Assn. Of Central Illinois, 324 NLRB at 56. Nor is the fact that job openings are posted on an Employer-wide basis, in and of itself, a sufficient basis for finding that a multi-facility unit is the only appropriate unit, particularly in the absence of a strong showing of regular employee interchange. Samaritan Health Services, above.

Although two radiation technologists out of the six or seven names that appear on the work schedule at Rohnert Park came to work at the clinic directly from the Santa Rosa facility without loss of seniority, one did so after being laid off for a period of time. In deciding whether the presumptive appropriateness of a single facility has been rebutted, permanent transfers between commonly owned and operated facilities are not given as much weight by the Board as regularly occurring interchange between two facilities. See Visiting Nurses Assn. Of Central Illinois, 324 NLRB at 56. The same is true of the radiation technologist temporarily assigned to

Rohnert Park during her pregnancy. These unusual types of temporary interchange do not amount to significant interchange, which would warrant overturning the presumption in favor of a single-facility unit. Moreover, the record does not indicate any employee interchange at all between the four Rohnert Park care partners and the Santa Rosa care partners. And, while there is testimony regarding interchange among RNs, these employees are not in the bargaining unit. In sum, in contrast to the situation in West Jersey Health System, above, 293 NLRB at 751, where 250 employees regularly rotated between divisions, the evidence of employee interchange between Rohnert Park and Santa Rosa is negligible. In the absence of substantial evidence of regular contact and interchange, a single-facility unit is appropriate. Compare Lutheran Welfare Services of Northeastern Pennsylvania, 319 NLRB 886 (1995), which involved a much higher degree of functional integration, employee interchange and common supervision in finding a multifacility unit appropriate.

The record indicates that there is little or no regular interaction among the employees of the Rohnert Park and Santa Rosa facilities. Indeed, the Santa Rosa hospital employees work in a large facility along with hundreds of employees in numerous different job classifications, while the clinic and neighborhood employees work in small facilities, with far fewer and diverse employees. I also note that the Rohnert Park employees have separate day-to-day supervision under Assistant Nurse Manager Marie Rogers. Nor does the fact that patients may be transferred from one facility to another warrant a multi-facility unit finding. Samaritan Health Services, above, 238 NLRB at 631. In these circumstances, I find that the Employer has not presented sufficient evidence to overcome the single-facility presumption with respect to the Rohnert Park radiation technologists and care partners.

With respect to the Neighborhood Care Program employees in the instant case, the record indicates that there is no interchange between them and employees at the hospital, and there is no question that they are separately supervised by Sandersfeld. While there is evidence of weekly contacts between the Neighborhood Care Program employees and hospital employees for the purpose of recruiting volunteers and obtaining supplies, they never substitute for each other and their job functions are completely different. These minimal contacts do not suffice to overcome the presumption in favor of the petitioned–for single-facility unit. Samaritan Health Services, above, 238 NLRB at 631

The record indicates that there is little or no regular contact between employees of the Santa Rosa and Rohnert Park facilities. While there is evidence of more frequent employee contact between the Neighborhood Care Program employees and the hospital employees, this contact is insufficient to warrant placing those employees in the unit, particularly where their jobs are not otherwise interchangeable. The record indicates that employees from all of the Employer's facilities attend committee meetings on a monthly basis, but there is no evidence of contact on a daily or even weekly basis.

The evidence of central control of labor relations, administration of personnel policies, payroll functions and environmental services does not warrant a contrary result. Nor does the fact that all employees are subject to the same wage structure and benefits and work in jobs with the same job description, warrant a different result. Indeed, in a case cited by the Employer, in which even the hiring was done centrally, NLRB v Purity Food Stores, Inc. 376 F.2d 497 (1st Cir. 1967), on remand from the First Circuit, the Board rejected the Court's view that 'it would be difficult to find a more integrated operation, or less difference among employees.' In a supplemental decision and order, the Board reaffirmed its previous determination that the respondent's Peabody store alone constituted an appropriate collective-bargaining unit. Although the record here fails to establish who does the hiring for the Rohnert Park and Neighborhood Care Program employees, the existence of such evidence would not change the result in the absence of a stronger showing of employee interchange.

The record also establishes that there is a sufficient degree of local autonomy to support a finding of a single-facility unit. Thus, the record reflects that there is relatively infrequent contact between the Rohnert Park employees' direct supervisor, Assistant Nurse Manager Marie Rogers, and the higher authority within the Employer's corporate structure, Merritt-Driver. Manor Healthcare, above, 285 NLRB at 228. In West Jersey Health System, 293 NLRB 749 (1989), hiring, firing, grievance handling and employee evaluations were the responsibility of a centrally located departmental director. By contrast, there is no evidence that the radiation technologists or care partners at Rohnert Park are supervised, scheduled, disciplined or evaluated by anyone other than Rogers.

I have considered the various cases cited by the Employer in its brief in support of its multi-facility unit argument, but find them to be distinguishable. In Mercy Hospitals of Sacramento, Inc., 217 NLRB 765 (1975), which preceded Manor Healthcare by a decade, the parties did not seek review of the Regional Director's finding that a multi-facility unit was appropriate. 217 NLRB 766, fn.4. In Kaiser Foundation Health Plan of Oregon, 225 NLRB 409 (1976), also decided before Manor Healthcare, there was a vigorous dissenting opinion, and the case consistently has been distinguished by the Board over the years.

The record is clear that there is no previous bargaining history with respect to the Employer's technical and non-professional employees, and while the RNs are represented, the record does not reveal whether the RN bargaining unit is a multi-facility unit. In the absence of a bargaining history on a more comprehensive basis, the Board has found on similar facts, also involving uniform corporate policies and centralized services, that outlying facilities maintained a separate identity from the health care system of which it is a part. Montefiore Hospital, above, 235 NLRB at 242; Samaritan Health Services, above, 238 NLRB at 633. Thus, under the Board's traditional standards, the presumption in favor of a single-facility unit limited to the Santa Rosa hospital located at 1165 Montgomery Avenue is unrebutted by the record evidence.

Finally, the Employer presented no evidence to suggest that the single-facility unit requested by Petitioner would threaten the kinds of disruption to the continuity of patient care that Congress sought to prevent when it expressed concern over the proliferation on bargaining units in the health care industry. In these circumstances, the Employer has failed to rebut the presumption that a single-facility unit is appropriate. Manor Healthcare, above, 285 NLRB at 226 and Mercywood, above, 287 NLRB at 1116. Accordingly, I find the petitioned-for single facility unit is appropriate. The Rohnert Park Center employees and the Neighborhood Care Program employees shall, therefore, be excluded from the unit.

5/ The Medical Technologists (Laboratory Clinical Technologists I and II)

The Employer asserts that Laboratory Clinical Technologists I and II (commonly referred to in the record and in this decision as medical technologists) employed at the Santa Rosa hospital are professional employees who should be excluded from the unit. Contrary to the Employer, the Petitioner asserts that the medical technologists are technical or non-professional employees who should be included in the unit.

At the time of the hearing, the position of Clinical Laboratory Manager was vacant. However, the Employer's Laboratory Information Systems Coordinator, Linda Mononi, testified that she and three other persons were temporarily overseeing the laboratory until a new Manager is named. According to Mononi, the job classifications employed in the laboratory are Medical Technologist I, Medical Technologist II, clinical laboratory assistant (herein called CLA), and phlebotomist. With respect to the disputed classifications, Mononi testified that there are five or six employees in the Medical Technologist II classification and 14 to 15 employees in the Medical Technologist I classification. Mononi herself is licensed as a Medical Technologist II. According to Mononi, the difference between Medical Technologist I and Medical Technologist II is that employees in the Medical Technologist II classification are responsible for setting up the testing instruments and analyzers.

The job description for the medical technologists indicates that they are required to have a BA or BS degree, followed by a one year internship in an approved Medical Technologist training program at an accredited institution, and must be licensed by the State of California as a Clinical Laboratory Scientist. Medical technologist Joan Stameroff, who has a BS degree in Zoology, testified that, in addition to her four years of college, the State of California required her to take three extra college level courses as a prerequisite to the internship. In her case, the required courses included clinical chemistry, path microbiology, and immunology. In addition to tests given during the internship, at the completion of the internship Stameroff was required to pass a two hour exam in order to be licensed by the State of California Department of Health Services as a Clinical Laboratory Scientist. The record reflects that Clinical Laboratory Scientists must thereafter take 12 continuing education credits each year in order to retain their license. Stameroff is a member of

the American Society of Clinical Pathologists (ASCP). The record does not establish how much medical technologists are paid.

The laboratory at the Santa Rosa hospital is divided into the specialty areas of hematology, urinalysis, chemistry, blood bank, and microbiology. According to the testimony of Medical Technologist Joan Stameroff, there are three medical technologists and one clinical laboratory assistant on the night shift where she works. More specifically, on the night shift there is one medical technologist for hematology, urinalysis and coagulation; a second to cover the blood bank; and a third who covers chemistry and microbiology. The record contains no testimony regarding the staffing in the laboratory on the day shift. Stameroff testified that all of the Employer's medical technologists are generalists in all the testing areas and work a rotating schedule whereby their assigned specialty area changes each day. According to Mononi, sixteen of the twenty medical technologists at the hospital are generalists who rotate through all of the sections except microbiology, which is a more specialized area. The medical technologists who do most of the microbiology work also do rotations in the other sections.

Mononi testified that the clinical laboratory assistant on duty receives a specimen when it arrives in the laboratory, enters the time of arrival into the computer and delivers it to one of the medical technologists. According to the testimony of Medical Technologist Joan Stameroff, when a specimen arrives in the laboratory, it has a label imprinted with a bar code that indicates the test to be run. Both witnesses agreed that some specimens need to be spun in a centrifuge, and that before any further work is done, an initial determination must be made as to whether the specimen is acceptable. Mononi testified that this assessment is made by the medical technologist. However, Stameroff testified that the clinical laboratory assistant might also be capable of recognizing an unacceptable blood sample in some instances. On cross-examination, Stameroff testified that, despite the increased automation, she still uses her schooling and expertise to make judgement calls about the acceptability of specimens.

According to Mononi, if a specimen is acceptable, the medical technologist runs it through an analyzer and decides if the results fall within the proper parameters for a normal result. Mononi testified that it is after the results come out of the analyzer that the medical technologist has to begin the analysis with respect to whether to accept or reject the results. The results are automatically entered in the computer where the medical technologist may view the patient’s diagnosis and determine if the test result is consistent with the patient’s condition and looks like a correct value or should be rejected. At this point the medical technologist runs a retest or requests a redraw of the specimen.

Although Stameroff testified that clinical laboratory assistants often spin the specimens and run them through the instruments, which is a simple procedure, both witnesses agree that the medical technologist is responsible for determining whether

the result that the machine prints out is accurate and eliminating factors that could affect the results.

Medical Technologist Joan Stameroff testified that it is becoming a lot more common for the clinical laboratory assistant to put the specimen in the analyzer if the medical technologist is busy. She testified that the clinical laboratory assistants are trained, know which instrument performs which test, and that it is not difficult for them to put a specimen on the instrument and hit the go button. The clinical laboratory assistants also run specimens through the centrifuge. The determination of whether a specimen is appropriate for analysis is dependant on the type of test and the color of the sample after it is spun.

Mononi testified that the medical technologists prioritize their work according to the source of each specimen, with higher priority given to specimens from patients in medical distress, the emergency room and surgery. According to Mononi, a medical technologist may decide to verify the results of a test by using a different method of testing on the same sample and comparing the results to determine the accuracy of the results. The medical technologist may request a redraw of blood from a patient if the result makes it appear that the first one was not drawn properly. However, only a physician may order additional tests.

Medical technologists must report “panic values,” i.e. dangerously high or low results, to the floor that is caring for the patient. If a panic value is registered, the medical technologist first reruns the test to verify the results. He or she then calls to see if the patient’s condition and medication is consistent with the test results. The medical technologist may reject results but must first attempt to determine an explanation for unusual results. The medical technologist has the discretion to discuss with the floor personnel (usually the RN on duty) and physician whether there is some other explanation for the abnormal result. (For example, a medical technologist may learn that a potassium level that is inconsistent with life is due to the fact that the blood was drawn from the same arm that has a potassium IV.) The medical technologists do not normally interact with the patient, however. In some instances, the panic results are submitted to the pathologist on duty.

Stameroff also testified that, because of the increasing number of automated instruments that turn out a computer printout with the parameters already set forth, the medical technologist’s job is not as analytical as it used to be. According to Stameroff, the instrument sends the test results to the computer system, using a bar code to identify the patient. The computer automatically indicates any results that are out of the normal range and flags results that are inconsistent with life. The computer requires that further action (a retest, redraw or floor inquiry) be taken in the latter case. There are also clearly posted standards for calling the floor nurse. For example, a reading of less than 3.0 on potassium requires that the floor be notified. This can be done by a click of the computer mouse that sends a copy of the results to the patient floor.

Mononi testified that the medical technologists often exercise discretion as to the particular methodology used to test a particular specimen; if a specimen is not appropriate for one procedure, another is used. The medical technologists perform a "delta check," i.e., a comparison with the previous test result to see the change between the two results. If the medical technologists see that the results of a hematocrit does not have the proper relationship to the results on the hemoglobin, they must investigate further. Similarly, the medical technologists are expected to recognize that a low platelet count on a complete blood count (CBC) is inconsistent with seeing platelets on a slide and to take further action to determine the correct result.

According to their job descriptions, all of the Employer's medical technologists are expected to be able to perform all levels of tests, from the simplest to the most complex. The medical technologists use about ten different pieces of equipment, instruments and analyzers to perform their work and are responsible for maintaining, cleaning and calibrating the equipment. The medical technologist on each shift must run quality control tests on these instruments and, if they fail to fall within the proper parameters, fix the problem before conducting any further testing. As an example, Mononi described having to replace the tubing on an instrument that measures blood-gasses. They also run tests as part of a quality assurance program that compares the quality of their results with that of other hospitals. The laboratory has a policy and procedure manual for the department and for each section.

According to Mononi, medical technologists sometimes make recommendations to physicians about what further tests should be conducted. They may also determine that the combination of tests ordered by the physician is unusual and call the floor to make sure the doctor's orders are correct. Medical technologists do not automatically assume that a test ordered by a physician is the correct test. If an order is determined to be correct but still raises a question in the mind of the medical technologist, the next step is to confer with the pathologist who in turn would consult the doctor who wrote the order.

In her testimony, Mononi gave examples of the work done in some of the sections. In the microbiology section, the medical technologists grow cultures in agar plates and later examine them through a microscope to identify the organism. Blood bank work involves blood typing, matching blood types, doing cross matches and antibody screens as well as preparing other blood products to be administered to patients. Blood bank work is done manually using test tubes and reagents. The results are visually determined using a small lamp with a mirror.

According to Mononi, if a medical technologist believes the blood product ordered by a physician does not fall within the proper parameters when compared to the tests done on the patient's blood, he or she refers the problem to the pathologist, who speaks to the physician. The medical technologist may also compare the blood product ordered to the height and weight of the patient and decide to suggest an alternative blood product to the doctor. Stameroff, however, testified that she has

never discussed the appropriateness of a particular blood product with a physician but, rather, that she alerts the floor and usually speaks with the nurse caring for the patient. Stameroff added that, in the six months preceding the hearing, criteria have been set for the appropriateness of blood products. According to Stameroff, a medical technologist may only question the appropriateness of blood products; they have no authority to deny blood products.

Mononi testified that about 60 percent of the hematology work is done by an instrument called the Coulter Analyzer. The remaining 40 percent of the work is done manually with a microscope. In the urinalysis section, she estimated that 50 percent of the work is done by the instrumentation, whereas in chemistry, 75 percent of the work is automated. None of the blood bank work is automated and almost none of the microbiology work is automated. Mononi emphasized that because the instruments have linear ranges, the medical technologist still needs to know the panic values.

Medical Technical II Joan Stameroff testified that the work is more automated today than it was when she did her internship 18 years ago. Stameroff testified that the chemistry tests are nearly totally automated; there is only one manual test in the chemistry area. Stameroff agreed with Mononi that the blood bank work was primarily manual. As to microbiology, Stameroff testified that on the night shift, all they do is very superficial microbiology work that includes reading gram stains. The clinical laboratory assistants are capable of setting up the agar plates for the medical technologists.

Analysis.

Section 2(12)(a) of the Act defines professional employees as those who meet four conjunctive criteria: employees must be engaged in work that is: (i) predominantly intellectual and varied in character as opposed to routine mental, manual, mechanical, or physical work; (ii) involving the consistent exercise of discretion and judgment in its performance; (iii) of such a character that the output produced or the result accomplished cannot be standardized in relation to a given period of time; (iv) requiring knowledge of an advanced type in a field of science or leaning customarily acquired by a prolonged course of specialized intellectual instruction and study in an institution of higher learning or a hospital, as distinguished from a general academic education or from an apprenticeship or from training in the performance of routine mental, manual, or physical processes.

Applying this conjunctive test to medical technologists, the Board has in most cases found medical technologists to be professional employees. Indeed, in Group Health Association, Inc. 317 NLRB 238 (1995) a five-member panel of the Board announced that it would apply a rebuttable presumption in all future cases that medical technologists are professional employees as defined in Section 2(12) of the Act and that any party seeking to rebut this presumption will carry the burden of

establishing that the medical technologists in question do not engage in the duties customarily assigned to this classification of employees.

More specifically, in Group Health Association the Board noted that some, but not all, of the procedures used by medical technologists were automated and that most medical technologists possess a bachelor's degree in some field of science (e.g., biology, chemistry, or physical science) and have completed a clinical internship. In the instant case, the medical technologists are required to possess a college degree and complete a one-year internship. The Board also noted that the majority of medical technologists are affiliated with certain nationally recognized professional organizations, including the ASCP, which maintain their own requirements for certification. Although the Employer's job description does not require its medical technologists to be members of the American Society of Clinical Pathologists (ASCP), I note that Stameroff testified that she is a member of ASCP.

The parties differ on the significance of the increased automation on medical technologists' work. However, in Group Health Association, the Board noted that, while automation has increased in the medical technology field, the essential intellectual nature of the work and the necessity for discretion and independent judgment in its performance has not been substantially eroded. Thus, the record shows that, like the medical technologists in Group Health Association, the Employer's medical technologists evaluate a specimen prior to testing to determine its viability and purity and may reject the sample as unacceptable. Like the medical technologists in Group Health Association, the Employer's medical technologists also calibrate the diverse and sophisticated equipment they use to ensure proper methodology and the functioning of the equipment.

In its brief, the Petitioner argues that the medical technologists utilize set parameters, programmed into the testing equipment and posted in the laboratory, to determine whether a testing result is normal. However, in Group Health Association, the Board found that the existence of rigid routines and protocols that medical technologists must follow for testing did not diminish the intellectual nature of their work or obviate the need for independent judgment and discretion because proper and accurate testing requires standard prescribed methodologies. In Group Health Association, the Board found that the non-automated, intellectual duties, which require the use of independent judgment and discretion, have not been taken over by the automated equipment and that a reasonable inference may be drawn that the automated tasks were those that were nonintellectual and nondiscretionary. Indeed, in this case, the record indicates that, once an automated result is produced, the Employer's medical technologists analyze and screen any results that the computer flags as falling outside an acceptable range. In doing so, the Employer's medical technologists use their experience and judgment to determine the possible causes of adverse test results and whether such results should be reported to the physician or whether the tests must be repeated.

Consequently, based on very similar facts, the Board concluded in Group Health Association, that every automated test performed by a medical technologist requires some level of pre-testing and post-testing analysis, as well as the monitoring of the equipment during testing. In Group Health Association, the Board rejected the view that automation has reduced the discretion of these employees and, accordingly, the need for independent judgment. Thus, as concluded by the Board in Group Health Association, medical technologists are not mere machine operators.

Nor does the fact that certain tests are initiated by the CLAs detract from the professional status of the medical technologists; for, as the Board recognized in Group Health Association, medical technologists frequently perform some routine or obviously non-professional tasks, which are attendant to their overall functions. The Board found that such tasks do not detract from their status as professional employees, because many, if not most, of their duties are intellectual and require the exercise of discretion and independent judgment. If anything, the fact that CLAs perform these nonintellectual tasks allows the medical technologists to devote a greater percentage of their time to their professional duties.

In sum, the record as a whole demonstrates that the Employer's medical technologists have advanced knowledge in a field of science and perform duties that are predominantly intellectual in nature which require the consistent exercise of independent judgment and discretion. Therefore, applying the Board's presumption that medical technologists are professionals and, in the absence of sufficient evidence presented by the Petitioner to rebut it, I find that the Employer's medical technologists are professional employees within the meaning of Section 2(12) of the Act. Accordingly, they shall be excluded from the bargaining unit.

6/ The parties stipulated that the Accountant, Accounts Payable Senior Clerk, and Senior Accounting Tech, should be excluded from the unit as business office clerical employees. The Petitioner would also exclude the Purchasing Buyer and the Purchasing Coordinator from the unit as business office clerical employees. Contrary to the Petitioner, the Employer contends that the Purchasing Buyer and the Purchasing Coordinator are technical or non-professional employees and should be included in the unit.

Purchasing Coordinator and Purchasing Buyer

The Petitioner contends that the Purchasing Buyer and the Purchasing Coordinator should be excluded as business office clerical employees, while the Employer seeks their inclusion as non-professionals. At the hearing, the Petitioner took the position that the Purchasing Coordinator is a supervisor within the meaning of the Act. However, it introduced no evidence in support of this position, and does not address the supervisory issue in its brief. Similarly, the Employer appears to have abandoned any contention that these are technical employees.

The parties stipulated that the Employer's Purchasing Supervisor, Ken Blenis, is a supervisor within the meaning of the Act. Blenis testified that the Purchasing Department purchases supplies, equipment and services for the entire hospital—including the administration, finance and nursing departments—with the exception of the nutrition and engineering departments and the pharmacy. The Purchasing Department does ordering for the Employer's Rohnert Park Clinic and the Neighborhood Care Program. Thus, the Purchasing Department serves the purchasing needs of the hospital staff and is responsible for ordering all medical supplies and office supplies, including computer hardware and software, and is responsible for the contracting of maintenance services and leased equipment.

The Purchasing Department is one of three divisions of the Employer's Materials Management Department. The other two are Sterile Processing and Central Services (which is the department where materials and supplies are stored). Blenis testified that he supervises the Purchasing Buyer and the Purchasing Coordinator. Blenis reports to Barbara Buck, the Director of the Materials Management Department, who in turn reports to the Employer's Vice President /Area, Chief Financial Officer, Don Miller. (Merritt-Driver, on the other hand, testified that the Purchasing Department reports directly to CFO Don Miller.) The other departments reporting to the CFO are Finance, Patient Finance, Budget and Reimbursement, and Information Systems.

Blenis testified that he has been employed by the Employer for the past four years, first as the purchasing coordinator, then as the purchasing buyer, and for the past two years he has been the purchasing supervisor. In addition to his supervisory duties, Blenis also works on cost containment and budgeting. Blenis testified that the Purchasing Department cost center has four persons: Barbara Buck; himself; the current purchasing buyer, Rose Marie Macioci; and the current purchasing coordinator, Rose Eagan. Blenis does not supervise any employees other than Macioci and Eagan.

Macioci has been employed as the purchasing buyer for approximately one year. Macioci is responsible for standing purchase orders, such as the regular shipment of laboratory supplies, landscaping, and blanket orders for equipment. As the purchasing buyer, Macioci interacts with the hospital staff members who do the ordering for their departments (usually the supervisors and directors), as well as with sales representatives. Macioci sends notices to the staff that purchase orders or contracts are due to expire and prepares a request for proposals to the vendors for those contracts. On three or four occasions, Macioci has made recommendations to Blenis and Buck as to which bid to accept.

The Purchasing Department office is located in the basement of the west wing of the hospital near Environmental Services, Central Stores and the Pharmacy. Much of the daily contact between Macioci and hospital staff occurs by telephone, as well as when hospital staff visit the Purchasing Department office. Less often, Macioci goes to the department to speak to staff about purchasing matters. Recently, the

Employer installed a computerized materials management system by which departments may order supplies electronically; however, most departments still use paper requisition forms to order non-stock items. After an order is placed, Macioci generates a purchasing copy.

Eagan and Macioci both interact with the Accounts Payable Department to resolve discrepancies between invoice and purchase orders. Eagan and Macioci communicate with the vendors if there is a problem with the goods or services supplied and have the authority to tell Accounts Payable not to pay a bill pending resolution of the dispute. Blenis estimated that of the time Macioci spends interacting with hospital staff, 25 percent is spent with Accounts Payable and the remainder is with other departments, whereas Eagan spends slightly more time (30 percent) dealing with Accounts Payable. The Accounts Payable Department is located some distance away in the basement of the hospital's east wing.

Blenis testified that both the purchasing buyer or the purchasing coordinator place orders for supplies. The difference between the positions is that Purchasing Coordinator Rose Eagan does purchasing on a daily basis for items like catheters and stents, whereas Macioci handles the standing orders for capital equipment and blanket orders. Blenis testified that the Purchasing Buyer spends most of her time on forms management and ordering. Macioci does her own typing, copying and filing. Blenis estimated that Macioci spends only 10 percent of her time typing. Purchasing Coordinator Eagan spends most (75 percent) of her time entering daily orders into the computer and placing orders either by fax or by telephone and checking confirmations on pricing. Eagan spends the rest of her time answering questions from the hospital departments and following up with back orders. Like Macioci, she does her own typing, copying and filing. Their work hours are from 8:00 AM to 5:30 PM weekdays on a 9/80 schedule, whereby they each work nine days in a ten-day period. Both are hourly paid employees and receive the same benefits as the full-time technical, business office clerical and non-professional employees.

Like Macioci, Eagan also communicates with staff in all the departments. Eagan does product research on price and availability through catalogues and by phone. For example, if the nursing department needs a particular type of scope, she will research what is available and at what price, and present the department with options. Blenis testified that Eagan interacts with the Catheterization Laboratory on a daily basis. Eagan also checks confirmations that come in after an order is placed, checks on back orders, and resolves any pricing issues that may arise. If a contract price goes up, Eagan has a discussion with the department about whether they will continue the service.

Purchasing Department employees prepare: summary reports of all supplies received by each department each month; a report of all items ordered each month; and, a report of all items issued by the central storeroom each month. The Purchasing Department interacts with the Central Services Department to produce

this report. The Purchasing Department also interacts with the Central Services Department regarding the ordering of substitutes for products that are not available.

No job description for the Purchasing Buyer was placed in the record. The job description for the Purchasing Coordinator indicates that the position "provides buying and secretarial support to the purchasing manager and coordinates disposal of surplus property." The job description also mentions that the Purchasing Coordinator maintains the Purchasing Department's files. The job description for the Purchasing Coordinator requires only a high school degree and secretarial training. Neither Macioci nor Eagan has a college degree. Macioci has five years of experience as a contract administrator for the government. In response to a question from the Hearing Officer as to whether the two positions were parallel, Blenis testified that the Purchasing Buyer is "a little more senior" position than that of the Purchasing Coordinator.

Macioci has additional contact with other employees as the chairperson of the Forms Management Committee, a hospital wide committee that meets once a month to develop improved forms and eliminate duplication of forms. Macioci and Eagan alternate in attending the Product Evaluation Committee meetings, which meet monthly. Blenis testified that he is also on this committee, which has 20 persons and is composed of clinical staff and department directors. The Product Evaluation Committee sends out product alerts that call attention to substitute products. Macioci also is on the Values Committee.

Analysis

Initially, I note that the Purchasing Buyer and Purchasing Coordinator are not technical employees, inasmuch as the Board has long held that purchasing buyers who are not required to have any post-secondary education are not technical employees. See Rhode Island Hospital, 313 NLRB 343, 358 (1993).

In cases involving health care institutions, the Board has found that the interests of business office clerical employees differ markedly from those hospital clerical employees whose functions are more closely related to the functions performed by service and maintenance (non-professional) employees. St. Luke's Episcopal Hospital, 222 NLRB 674, 675 (1976). The Board generally includes hospital clerical employees in a non-professional unit, but consistently excludes business office clerical employees from such units. Rhode Island Hospital, above, 313 NLRB at 359. In its Rulemaking, the Board acknowledged that individual clerical classifications would have to be decided on a case-by-case basis, citing Mercy Hospital of Sacramento, 217 NLRB 765 (1975). The question, therefore, is whether the Purchasing Department employees are business office clerical employees, who are excluded from the unit, or hospital clerical employees similar to the Administrative Assistant job classification that the parties stipulated shall be included in the unit of non-professional employees.

In several cases, the Board has stated its guidelines for determining whether clerical employees are business office clerical employees or are hospital clerical employees. In St. Luke's Episcopal Hospital, the Board stated that, "Business office clericals are those clerical employees who, because they perform business office functions, have minimal contact with unit employees or patients, work in separate geographic areas of the hospital, or perform functions, separate and apart from service and maintenance employees, and thus do not share a community of interest with the service and maintenance unit employees." 222 NLRB at 676. Similarly, in William W. Backus Hospital, 220 NLRB 414, 415 (1975), the Board noted that the community of interest of business office clericals is not related to that of the service and maintenance unit because "[t]hey work in a department separate and apart from the service and maintenance employees, perform business office work which is, at the maximum, tangentially related to unit work, have minimal contact with unit employees, and are supervised by different individuals."

By contrast, the Board stated that "[h]ospital clericals are those clericals who work side by side with service and maintenance employees in various departments throughout the hospital, performing clerical functions. Their work and working conditions are materially related to unit work; they have continual contact with unit employees and are generally supervised by the same supervisors that supervise unit employees." William W. Backus Hospital, 220 NLRB at 415. See also the discussion of business office clericals in the Board's Rulemaking (284 NLRB at 1562-1565).

Applying the above criteria to the facts of the instant case, I note that there are no significant differences in wages and benefits between these employees and those of the full-time technical, business office clerical and non-professional employees. While the record does not contain sufficient information to make a comparison of their hours of work, it does indicate that the classifications in dispute work from 8:00 AM to 5:30 PM weekdays. Thus, they are likely to have work hours that are more consistent with the business office clerical employees than with those non-professionals who work shifts on a 24-hour schedule. See Rulemaking, 284 NLRB at 1563.

It is noted by the Employer that the Purchasing Buyer and the Purchasing Coordinator spend a large percentage of their time in contact with department staff. However, it is not clear from the record that these contacts are with non-professional unit employees. To the contrary, the record indicates that the contacts are with the department heads who are in charge of ordering supplies for their department. In most cases these would be admitted supervisors and management employees who are excluded from the unit. Thus the record does not establish that the Purchasing Buyer and the Purchasing Coordinator have frequent contacts with employees in the petitioned-for unit. Accordingly, I do not give great weight to this factor, particularly where the record also indicates that the Purchasing Buyer and the Purchasing Coordinator also have significant contacts with business office employees in the Accounts Payable Department.

I find the Employer's reliance on Rhode Island Hospital, above, to be misplaced. In that case, the Board did not consider whether the buyer and senior buyer at issue were business office clericals because the union sought their inclusion as non-professional employees and the employer sought their exclusion as technical employees.

The record establishes that the Purchasing Buyer and the Purchasing Coordinator work in a separate geographic area located in the basement of the hospital. More importantly, the record is clear that the Purchasing Buyer and the Purchasing Coordinator have separate supervision from the non-professional employees in the petitioned-for unit. The absence of common supervision is traditionally a strong factor in determining community of interest. Nor does the record contain any evidence of interchange between the Purchasing Department employees and the positions in the petitioned-for unit, which are positions more directly involved in patient care. Thus, the Board noted in its Rulemaking that there is minimal interchange between employees in service, maintenance, technical, or professional jobs and those in business office clerical positions. 284 NLRB at 1563-1564.

The Employer contends that the two classifications at issue are in the Purchasing Department, which is part of the Materials Management Department, and that the parties stipulated to the inclusion in the unit of three classifications in the Central Services Department (Materials Handlers, Inventory Controller and Central Service Technicians), which is also part of the Materials Management Department. However, this contention ignores the fact that the Purchasing Coordinator works in a department within a larger grouping of departments reporting to the CFO that are primarily finance related (Finance, Patient Finance, Budget and Reimbursement, and Information Systems). The Board's Rulemaking noted that the ultimate supervisory responsibility for business office clerical employees generally rests with financial administrators. 284 NLRB at 1563. Aside from the stipulated employees in the Central Services Department, the majority of employees working under the Vice President / CFO's authority are business office clerical employees. As noted above, the Purchasing Buyer and the Purchasing Coordinator have significant contacts with the Accounts Payable employees. In these circumstances, I find that the Purchasing Department employees share a closer community of interest with the Employer's business office clericals than with the Central Services Department employees.

In so concluding, I note that in Baptist Memorial Hospital, 225 NLRB 1165 (1976), cited by the Employer in its brief, the Board found a purchasing secretary-buyer to be included in a service and maintenance unit. In its decision, the Board concluded that, because the purchasing secretary-buyer received requisitions from various departments and typed invoices and order forms, she spent a substantial amount of time performing functions directly related to the care and treatment of patients. By contrast, in a more recent case, the Board characterized "billing, dealing with insurers, and *purchasing*" as "typical business office functions." (Emphasis supplied.) Charter Hospital of Orlando South, 313 NLRB 951 (1994). I find that the activities of

the Purchasing Buyer and the Purchasing Coordinator described in the record are more akin to typical business office functions than to the care and treatment of patients. Unlike the admitting clerks, who have direct contact with patients, the record indicates that Purchasing Department employees have no contact with patients. Based on the foregoing evidence and, in particular, the fact that the Purchasing Buyer and the Purchasing Coordinator are separately supervised by the Purchasing Manager, I find that they are business office clerical employees who are not included in the bargaining unit.

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